

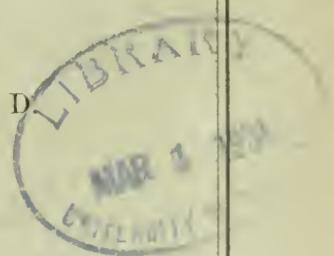
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WILLIAM S. EDGAR, M. D.
AND
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THE SAINT LOUIS
Medical and Surgical Journal.

SEPTEMBER, 1877.

Original Communications.

*THE APPLICATION OF OIL TO THE SURFACE
OF THE BODY.*

By THOS F. RUMBOLD, M. D. St. Louis, Mo.

During the last three years, I have prescribed the application of an inunction to the surface of the whole body of every catarrhal patient who was *thin* in flesh, and whose skin was *dry* and *rough*. Such patients are very liable partly on account of this dry condition of the skin, to "take cold" during those seasons of the year in which there are sudden and great changes of temperature; I have repeatedly noticed that these applications, materially assist to increase the warmth of the body and decrease the cold rigors that course up and down the back.

The beneficial effects following the inunction of children have been, as a rule, more marked than in adults. I think that this difference is mainly owing to the applications being made with more regularity, and with greater thoroughness on the former than on the latter.

I was first led to try these applications, in 1859, by reading an article written by the late Sir James Y. Simpson of Scotland. He contributed the results of his investigations on the "External Use of Oil" to the Edinburgh Monthly *Journal of Medical Science*, Oct. 1853. This paper is republished in his works on obstetrics. Second Series, page 441.

From the thoroughness of the observations and the very satisfactory results following the applications of the oil externally, I resolved to try this means for the amelioration of a case that I then (1859) diagnosed acute phthisis. The effect of the applications was all that could be desired. The profuse night sweats were at once lessened and, after the fifteenth nightly inunction, entirely checked. The patient slowly recovered, made a trip to Pikes Peak—at that time a place of great attraction in the west—and at present is living in Wisconsin, in robust health.

I employed the applications on several other patients; whenever they could be induced to make the inunction in a proper manner, the benefits were marked, but the impossibility of procuring an oil that did not become exceedingly offensive on the body of the patient, compelled me to desist from using it, except in cases of children. As these little sufferers remained in the house the disagreeable smell offended the nostrils of their parents only, who were ready to undergo almost any discomfort so that it pointed to the patients recovery.

As we now have an article, called by the arbitrary name of "vaseline," a product of petroleum, which is inodorous, and remains so while on the body, and which may be applied to the skin of the most delicate patient, not only without the least discomfort in any respect, but causing a pleasurable sensation, the time for reviving the practice of making external inunction has fully arrived, not to be again driven into obscurity by the disgust of the patient for the disagreeableness of the agent applied.

I think the most appropriate manner of again drawing the attention of the profession to the advantages of the applications of liniments to the whole of the surface of the body, is to reproduce so much of the original investigator's paper, as will show both the history of its origin and the results of its practice, as achieved by him.

The whole article is so decidedly practical and written in such a connected manner, that it makes it difficult to quote from it without, at the same time impairing to some extent, the force of that which is quoted.

In this article he says, that his attention was called by a medical friend "to the healthy and robust appearance of the operatives in the woolen manufactories," and that the operatives "themselves attributed the immunity which they enjoyed, from consumption, to the free external application of oil to their bodies which occurred in various parts of the manufacture of woolen fabrics."

In the further observations on this subject he found that the same immunity existed in other woolen factories. Another medical friend writes to him in the following terms: "I find here the opinion is very general or rather universal, that the employment is remarkably healthy, the workers being rarely, or almost never known to suffer from consumption or other chest affections, such as coughs, bronchitis or asthma."

Dr. Wilson of Inverness writes to him that "it is a popular notion that the workers employed are peculiarly exempt from phthisis and scrofula. The proprietor and manager of the mills inform me that they have invariably observed delicate looking and weakly children improve after admission to the works."

Dr. Joseph Bell, one of the medical inspectors of the factories of Glasgow writes to him as follows:

"There is no doubt in my mind, that the workers in our woolen factories are more robust, florid and healthy looking than those employed in our cotton factories. I have seen several workers enter the woolen factories

pale and emaciated, having been previously employed in cotton-mills, become, in the course of a few months, fat, ruddy and in every respect contrasting strongly with their feeble, sickly appearance when I first examined them. One woman, who labors under chronic bronchitis, informed me that she is obliged to work in the woolen factory during the winter and spring months, as otherwise her cough and dyspnoea become intolerable. I have examined two other females who exhibit symptoms of incipient phthisis, but after working a few weeks in the wool-mills, these symptoms disappeared, and their general health became excellent."

Dr. Simpson received from other physicians letters to the same purport.

On the cause of the comparative exemption, some have attempted to explain that it was their hygienic *state* that was the possible result of their healthy condition, or their exemption from chest complaints, or that it was attributable to the sanitary nature of the factory labor itself.

These two supposed explanations he examines carefully, and concludes as follows: "In other words, the multiplied testimony adduced regarding the health of the workers at the numerous cotton-factories of this country shows that the mere nature of the work at the mill produces no immunity in those employed from consumptive and tubercular affections, and consequently it follows, that if any variety of mill-working, such an exemption was found, this exemption could not be ascribed to the mere character of the factory labor or mill-work itself. And when we find that, while the cotton mill-workers are not free from consumption and struma, the wool-mill workers are comparatively exempt, we must evidently search for the cause of this difference and exemption in some peculiarities connected with the wool making itself."

"The great difference and peculiarity in woolen-mills, consists in the fact that while the hours, the occupation

&c, are much the same in each, in the woolen-mills a very large quantity of *oil* is used, and the bodies of the workers are brought in various ways freely in contact with it. It is, I believe, in this one item that the great difference between cotton-working and wool-working consists; and, it is to this material, the oil, as freely used in some of the processes of the wool-factories, that the operatives themselves universally and, as I believe, properly, attribute the salutary nature of their occupation."

"In corroboration of the truth of this popular belief that the good effects of the woolen factory labors are ascribable to the oil employed, I have to state two points viz; that—"

"*First*, Similar exemption from scrofula and consumption is observed in other classes of workmen whose employment bring them in the same way freely in contact with fats or oils, as tallow chandlers, oil men &c, and—"

"*Secondly*, In the wool factories the degree of exemption among operatives themselves is by no means equal in all the processes of the manufacture, but is regulated by the more or less 'oily' nature of the departments of work in which they are engaged in the mills; so that they in general, markedly improve in appearance and health when set to work at the more oily processes; and often as markedly decline after leaving them."

This is followed by giving the weight of some of the workers at the time they commenced to operate in the more oily employments, and weighing them after they had been at work a few months, showing a very marked increase. "The fine appearance," he adds: "of the young workers, their rapid improvement when set to work in oil, their declension when they discontinue it, leave no doubt on my mind that the oil is the salutary agent."

In mentioning the mode or channels by which the oil may enter the system, he says. "Under such circumstances, we may suppose the oil to enter the bodies of the operatives by one of two channels, either by inhala-

tion through the mucous membrane of the lungs, or by cutaneous application and absorption." He concludes on this point that—"In all likelihood the more important, if not the only channel by which the oil gains access to the system in the case of the woolen operatives, is by its cutaneous application." * * * * "In the living human subject, we can readily gain clinical proof of the facility with which warm oil can be rubbed into the skin by watching the rapidity with which the liquid disappears from, and is absorbed from the surface of those who use oil-frictions, and particularly in the case of such persons as have followed the practice for a considerable time, and in whom the power of cutaneous absorption is hence increased. Besides we have a further proof of this cutaneous absorption of oil, in the fact that those who use oil-frictions show exactly the same special constitutional effects from this mode of introducing it, as those who introduce oil into the system by swallowing it."

Of the systematic oil-inunction, as a medicinal measure, he says:

"In tubercular and other cases, these effects are sometimes as distinctly, though perhaps not as frequently, obtained from the external inunction of olive oil as by the swallowing of codliver oil. I have seen a similar amelioration in the constitutional and local symptoms of the malady, and a similar improvement in the general health occurs under the one as under the other practice; one may, if necessary be sometimes temporarily substituted for the other; or both employed at once when there is no contraindication to their combined and more certain action. *The restoration of the function of the skin, and the suppression of the hectic perspiration more rapidly and surely follows external inunction**. The increase in the weight of the body, which has been so much and justly insisted on as a favorable sign under the internal use of cod-liver oil, is occasionally most marked un-

— * The Italics are mine. R

der the external use of olive oil. In a case in which this increase was specially watched, under external oil-inunction alone, the patient, who was carefully weighed, in forty-two days increased 24 lbs. in weight, a rate nearly as high as any, I believe, ever observed to occur under the employment of cod-liver oil internally. This patient's stomach could not retain cod-liver or other oil in any form that was tried. I have seen a child two years old increase in weight an ounce a day, for eight weeks, under assiduous oil-inunction, its stomach having for some time previously rejected oils, and most other food, when swallowed. And in the external as in the internal use of oil, increase of weight obtained, is often greater than the mere weight of the oil introduced into the system."

In mentioning the diseases and circumstances in which oil-rubbing is indicated he says "In inanition, by whatever case produced, and *particularly* when dependent on mal-nutrition or mal-assimilation, and combined with a *dry* or *disordered state* of the *skin*, the practice is often most advantageous."* * * * "The practice itself guards weak constitutions against the effects of changes of temperature and weather; and the feeling of cold and tendency to catarrh and chilliness, attended upon various debilitated states, is sometimes entirely arrested and averted by oil—inunction.*

He recommended that the oil selected ought to be bland and inodorous; that it should be applied moderately warm, and with a considerable amount and duration of friction; that the oil and friction should be applied to the whole cutaneous surface of the trunk and extremities, using "about a wine glass of oil;" that the application may be practiced twice or oftener in twenty four hours, especially with children; that the best time for a single daily oil-inunction is immediately before retiring to bed and that to save the bed cloths, the patient should

*The italics are mine. R.

sleep in a dress of flannel, linen or other material that stretches beyond the feet. He also recommends that the body be occasionally sponged with tepid water immediately before an application is made.

The greatest hindrance to this practice, was, as I have already mentioned, the impossibility of procuring an oil that was inodorous, this, I think is the only reason why Dr. Simpson's suggestion's have been allowed to slumber for years, but happily this obstacle is now removed, as we have in "vasoline," an article that is perfectly inodorous, and is not liable to become rancid on the body, as does the olive oil. The next objection to the practice, is its tediousness, as it requires the daily dedication to it of the ten or fifteen minutes that is usually required to perform the inunction fully and perfectly.

The best means of applying the inunction is with a woollen rubber. This rubber is made of ten or twelve thicknesses of flannel, these layers are stitched on the face-side of a cotton glove, in this way it is more easily held by the person making the application.

About one teaspoonful of the "vaseline" is spread on the woolen rubber—after it is once saturated by the inunction—and held close to the fire until it is *quite hot*, it is then applied in this hot condition to the surface of the body with considerable pressure and with a rapid motion.

The room in which the inunction is applied, should be warmed to about 90° F. All of the clothing of the patient should be removed except the stocking-knit drawers, and stockings. The exposed portion of the body and the arms should be well rubbed with the *hot* woolen rubber, upon which the "vaseline" has been placed. The rubbing should occupy from three to seven minutes on an adult, and half this length of time for a child: At the completion of the anointing of this part of the body, the stocking-knit under shirt should be put on. The drawers and stockings are removed and the remainder of the body

treated in the same manner, occupying about the same length of time.

The immediate effect of this application on all individuals who are *thin in flesh*, is the production of a sensation of warmth over the whole of the body, the feet and hands included, particularly so, if these extremities have been habitually cold. The sensation of cold chills coursing up and down the back, between the shoulders is soon arrested, and if the patient has been subject to night sweats, these also are soon abated or they will entirely disappear.

Of course the effect of the friction is to redden the surface, by increasing the circulation, and thus induce a warmth of the body, but I believe that it is due to the induction that this warmth is made *permanent*. The following experiment, which I have had my patients try quite a number of times, indicates that the permanency of the warmth is owing to the presence of the "vaseline" viz; To rub one extremity with a hot flannel alone, and another with a flannel that had the hot "vaseline" on it. The extremity having the annointment applied to it, remained warmer during the day, than the one rubbed with the hot flannel only.

CROUP AND ITS TREATMENT.

By R. S. COWAN, M. D. Pres. Macoupin County Medical Society.

Pseudo membranous Croup, be it sporadic or Epidemic, is always looked upon by intelligent physicians as one of the most alarming and dangerous diseases to which children are subject. The greatly neglected branch of our art—Therapeutics—adds nothing in the way of new weapons whereby to combat, so formidable an

enemy. The mortality bills remain unchanged. Under the head of extracts from current Medical Literature in the St. Louis Medical and Surgical JOURNAL, I find a short article on the treatment of croup which to my utter astonishment adds nothing new, but recommends all the old and well tried remedies that have so signally failed in the hands of the many that have tried them. The notice of this article prompts me to give to the readers of your most valuable JOURNAL a short article upon the above disease. In the winter of 1871 and 1872, there prevailed in this part of Illinois, an epidemic which destroyed nine out of ten of all the children that were attacked. The disease had progressed some time before any case came under my care, it being confined at that time to a section of country east of me some ten miles; being called one day in this neighborhood, to see two children, aged 3 years, when it was said they were suffering intensely from this disease, and being aware, that all the children in this neighborhood had died that had been attacked, I very naturally dreaded the undertaking, and would have much preferred having been called to a simple case of scabies, or a case of intermittent fever. I had learned from the physician in attendence the treatment he had adopted and that it was the treatment recommended by Flint, Wood, Watson and others, which consisted of Emetics Relaxants, Antiphlogistics &c. These he had used energetically and to the fullest extent, now this was of considerable help to me knowing what had been done and failed, I very naturally thought I must try some other plan of treatment. It occurred to me from what I had seen of the above mentioned remedies that they had sufficient trial and being attended with no success but the reverse in every instance, that they were to say the least useless and possibly might have done harm. That the relaxing heating and depleting process might facilitate rather than prevent the exudation of the false membrane; the capilliaries of the larynx and trachea

being distended with blood was certainly in a very favorable condition with the help of these blood inviters (the relaxants and stimulants) to pore out the very thing to be dreaded the pseudo-membrane, believing the foregoing to be true we concluded that a rational treatment would consist in some remedy or plan by which this congestion and inflammation might be aborted without the aforesaid effusion; and that some remedy by its specific action would constringe or reduce the amount of circulating fluid in these parts would certainly prevent and to some extent relieve the patient. In thinking of remedies that had specific action (not that I believe much in the specific action of drngs) upon this point I at once fixed upon Belladonna, remembering its desicating effects upon the mucous membrane of the throat constringing the arterioles and capillaries I concluded it was worth a trial, all other remedies having signally failed. I prescribed Fluid Ext-Belladonna gtt ii every hour until the effect of the Drug was produced, which was to be determined by the dilatation of the pupil and the erethematous appearance of the skin, of the face and chest; continued the remedy until the next day which was about twelve hours the patient then being well under the influence of the remedy I reduced the dose to one and a half drops every three hours for forty eight hours, at which time my patients were improving, I then left them with the following prescription. R Syrup Squills, Syrup Senega, Tr. Tolu. Comp. Spts Aether $\frac{1}{2}$ i. Ammonia Meriate Potassæ Chlorate $\frac{1}{2}$ i. Fluid Ex-Belladonna 5 ss. M. Sig. Tea-spoonful three or four times a day; they recovered quite well; these were my first two cases treated in this way, I had several after these and in connection with the above I gave grain doses, of Quinia Sulphate in solution with Tartaric Acid and Syrup Amygdala. In the winter of 1873 and 1874 I had as my partner Dr. R. J. Mitchell, the disease made its appearance this winter again, and with the Belladonna treatment in the onset of

the disease we were usually successful. I was called to a little girl that had been attacked twelve hours before my arrival I tried my remedy but could not get the effect in this case owing to the difficulty in getting her to swallow the remedy, this was about noon, at night suffocation became imminent and Dr. Mitchell being called to assist me, we performed Tracheotomy, letting the tube remain in the wound for fourteen days. She made a good recovery, some two or three days after the operation on this little girl three and a half years old, her brother five years old was attacked; I at once put him upon the Belladonna and succeeded soon in bringing him under its influence after which he soon recovered. We would mention here that every patient has his idiosyncracy in regard to taking the drug so that it is necessary for the physician to feel his way by commencing with a minimum dose. Yet patients with croup resist the drug very much and those who try it will find that it requires a much larger dose in this disease than in any other. Remember it prevents the exudation of the false membrane by its drying effect upon the mucous membrane, and I would further more state that the above epidemic was that of acute croup, it was confined to children and carried with it none of the diphtheritic symptoms usual in epidemic diphtheritic croup. In the treatment of this complaint if there should be difficulty in getting the child to swallow the medicine, I would recommend the hypodermic injection of atropine; from my experience in the use of this remedy, if it is early used, it will almost certainly abort the disease. Physicians during an epidemic should teach the people that to procrastinate in this disease is only to wait for a funeral. I believe that an exudation is impossible, when the patient is under the influence of this medicine.

URETHROTOMY, INTERNAL AND EXTERNAL WITH ILLUSTRATIVE CASES.

By W. HUTSON FORD, M. D. St. Louis, Mo.

Six principal methods of dealing with strictures of the Urethra are now practised, viz: 1st, intermittent dilatation; 2nd, continuous dilatation; 3d, overdistension; 4th, divulsion; 5th, cauterization; and 6th, division.

Under this latter head are embraced the operations of external urethrotomy, subcutaneous urethrotomy, and external urethrotomy, *with* and *without* a guide. Intermittent dilatation by bougies or sounds is more generally employed than all the other methods put together; it is certainly the simplest, easiest, and least dangerous mode of treating strictures, all it lacks is efficiency and permanency, nor is it by any means applicable to all cases. When injudiciously attempted or rashly pushed in irritable states of the urethra and bladder it is capable of originating very grave trains of morbid action. In *such cases* it bears the same relation to cutting operations that lithotripsy does to lithotomy and its employment should be controlled by the same general laws of urethral Surgery.

But in recent strictures, when the bladder is healthy, the condition of the patient tolerably good, and the stricture not too small, the method may be safely, and up to a *certain point*, very satisfactorily practised—especially when time is not a special object. But dilatation cannot be practised or pushed beyond a certain point, which is rarely that demanded by views now gaining ground.

This is essentially a popular method of treating stricture, for it is adapted to the temper of the patient, usually but little inclined at first to taste the knife, as well as to the general practitioner who scarcely regards it as strictly of surgical character. In the majority of cases a certain amount of success is readily enough attained; but

in no small number, inflammatory conditions are kindled difficult to abate and requiring the bold and free use of the knife eventually. Under favorable circumstances, the patient after a few weeks is able to pass a stream of urine, which his doctor tells him is large enough for all practical purposes. A hole of the size of No. 10 or No. 12 (English) is usually imagined quite sufficient for emptying the bladder easily, and but little is commonly known of the high numbers now employed in this mode of dilatation under the demands of improved treatment and more exact physiology. The patient is consequently dismissed, and told he is cured: he is ordered to introduce a No. 10, 12 or 13 English bougie, the last one used probably by the medical attendant, at decreasing intervals for the balance of his life. With an imperfect urethra and fretted bladder, he goes out to struggle at leisure against an almost inevitable recontraction, and to await the development of prostatic and vesical inflammation, neuralgia of the neck, and renal disease. At the best surgery has but half done her duty by him.

Continuous dilatation requires that the patient lay aside business and remain mostly recumbent for ten days or a fortnight. A small-sized bougie,—one that passes easily, indeed lies loosely in the canal is introduced and tied in; it need not quite fill the stricture and the point must not project into the bladder. Within twenty-four hours, if the instrument is tolerated, the stricture is found to be considerably dilated, mucus being freely poured ed out from the urethral walls, if all goes well. The next higher number is introduced, and tied in as before. The patient voids his urine by the side of the bougie, which must be well secured and not too flexible, lest it be washed out by the stream of urine. Every day or two a still larger sized bougie is to be passed and secured, provided it slips in quite easily. No pressure whatever upon the walls of the strictured portion of the canal is admissible: the theory of dilatation by the method is wholly different

from that by intermittent passage of bougies or conical sound. Generally about the end of the second week No. 17 or No. 19 (American) may be introduced. The process may be interrupted at this point and the patient dismissed with instructions as before to pass the sound regularly at increasing intervals. This he will probably do faithfully enough for a certain time—but he will some time or other get tired of the sound, or fancying himself secure, will intermit its use; or sickness, business, a journey, or something of the kind deeply engrossing his thoughts, will prevent the introduction of the bougie for a month or two. The stricture will then steadily recontract, and the urethra become inflamed behind it; or more exactly, the previously existing subacute inflammation, which always affects the urethra just behind a stricture, will be rekindled into activity either by taking cold, by a "gastric embarrassment," or by indiscretion in eating and drinking so that a sudden congestion will precipitate an attack of *retention of urine*. When this is relieved the stricture will be found as small as before and the entire work of dilatation will have to be done over again.

Though usually very safe, certain dangers attend this method especially where any abnormal irritability of the urinary passages exists. Rigor and urethral fever, unless severe, need not interrupt the process; it is not often that acute vesical or prostatic trouble, or epididymitis is excited. But in these days, we do not like to tie a bougie or catheter in the bladder unless for some very pressing reason; the practice is recognized as always hazardous and is avoided in American and advanced English surgery as much as possible. It is no light thing to keep a foreign body in contact with ten square inches of exquisitely sensitive surface for days together, in a canal whose sensibility ranks with that of the conjunctiva; ulceration of the urethral walls is almost certain to occur and superficial ulcerations of the strictured

area are to be regarded as *inseparable* from this mode of treatment.

Thompson's method of "overdistension" for which he devised his "dilator" as a modification of Perreve's, and Holt's process, consists in slowly dilating the stricture at a single sitting, by means of an instrument whose parallel bars are made to separate from each other in bowed lines by screw-power in the handle—this instrument is the original of numerous forms of dilators and dilating urethrotomes now accumulating upon us. Thompson advises that the force be applied as slowly as possible, so as to rupture as little as possible and to overdistend as much as possible. The procedure is limited by its author to strictures within the bulbous region; the stretching should be carried as high as *No. 20 or 24 English*, only recent strictures, not of traumatic origin are to be treated in this way; it is totally inapplicable to old irritable and resilient strictures. It cannot be regarded otherwise than as an expedient by which a full sized sound may be passed at once through a stricture, whereby the patient is saved several weeks of treatment by intermittent dilatation, or the trouble of recumbency by the continuous plan. It can hardly be doubted that by this method there is nearly always more or less rupture of tissue, however carefully it be practised; the process consequently partakes very distinctly of the nature of *dilection*, and is largely liable to all objections legitimately urged against that violent procedure.

The last named method originally introduced by Mr. Holt, of Westminister Hospital, London, is an outgrowth from Wakley's, Hutton's and Maissounav's practice. Holt's instrument is an improvement upon Perreve's of 1847; and Voiltemier's is an improvement upon both of these. All the dilators act by the sudden introduction, at one sitting, of rods of the calibre desired between two slender bars fastened together at the point, previously insinuated through the stricture.

These methods of divulsion not long since held a very high place in the treatment of stricture of the fixed curve of the urethra. Holt is well known to claim that by the use of his instrument the mucous membrane is not really torn, but stretches and escapes injury, or at least rupture, during the shock of dilatation, while rupture affects only the submucous structures whose consolidation and contraction constitute the stricture. As far as these statements go, many autopsies undoubtedly corroborate the assertion; but if we are naturally repelled by the *too-apparent* violence and *unsurgical* inaccuracy and roughness of this method, notwithstanding Thompson's decidedly reluctant and partial admissions, and the fact of its acceptance by many English and American surgeons of undisputed authority, it must be *emphatically* condemned when judged "*by its fruits.*" Many deaths of late years, directly caused by this operation have come to light. Tibbits in 1874 reports two deaths by *septicæmia*, though the injury to the mucous membrane had been of the slightest. Bryant charges it with earlier relapse than other methods. Teevan in "The Lancet" for May 1874 uses the following language with regard to it: "As for divulsion," "*dilatation instantanea*," "immediate treatment," or any other synonym by which the process of tearing open a man's urethra may be concealed, it has fully justified the almost universal condemnation passed upon it by Parisian surgeons. It has acquired the unenviable distinction of being the most fatal operation known, for stricture, and I am aware of thirty deaths following its use by different surgeons. The operation has been condemned by Sir. William Fergusson, Mr. Thos. Bryant, Mr. Walter Coulson, Mr. O. Pemberton, Mr. H. Smith, Prof. Stokes and others."

Divulsions seems to have been invented for the assumed benefit of patients who stand in awe of a sharp edge, and for the comfort of practitioners but little versed in perineal anatomy, or distrustful of their ability to

cope with haemorrhage; to all such it proves but a treacherous friend.

The treatment by caustics as usually practised is clumsy and inefficient. It is very difficult, impossible to any but an expert, to limit the action of the escharotic to the parts affected. It is generally very painful, and much local and general reaction often follow. The use of the agent can never be free enough to open up the canal to its proper calibre without great and unnecessary destruction of tissue, as compared with the lumen gained by a simple knife-cut. The ultimate effect of the caustic moreover is wholly objectionable when contrasted with that consequent upon the use of the knife or even of divulsion, for the resulting cicatrix is necessarily *annular*, of the very worst order therefore, and sure, by the process of contraction, to reproduce the original condition in an aggravated form. On the other hand, in all the cutting operations, and even in divulsive splitting, more or less imperfectly, the line of cicatrix of course follows the line of division, and is therefore parallel to the axis of the urethra, and though contraction occurs, it is not effected in such a way as to *narrow the canal*; when this happens after such methods it is in consequence of the contractile tendency of the stricture itself, or of incomplete division. This treatment is advocated by M. H. Smith in certain cases of very close stricture as preliminary to other procedures. Mr. Teevan himself has recourse to it occasionally. (See "Lancet" April 1874.) He gives us the details of a case where the use of the "bougie armee" was eminently proper. It may be said that this method should be practised in cases of *impassable strictures* only, when the question of melting down the indurations from within, or of operating from without by "the most difficult operation in Surgery," (viz: the "Boutonniere," or "External urethrotomy without a guide,") should be solved in favor of cauterization. M. Teevan proposes to apply the caustic through an endoscopic tube in such cases.

Internal urethrotomy—division by a cutting edge from within, ranks at present, of all operations for the relief of stricture, as the most, artistic, effective, and least dangerous. The progress of urethral surgery in this respect has been very rapid and highly satisfactory, of late years.

Many exceedingly ingenious instruments have been devised for this operation, some of them possessing great and apparently permanent value. Of these some cut from before backwards only, others from behind forwards, and others again,—the simplest forms, in either direction.

As the indications vary greatly, differing in almost every case, according to the condition of the patient of the bladder and kidneys, the presence of various complications, the character and situation of the stricture, the same instrument cannot always be employed. Urethral diagnosis, by the aid of special diagnostic instruments has now become so exact, and the instruments for the division of stricture are of such perfect workmanship, that the Surgeon is able with the greatest precision to cut the stricture, the whole stricture, and nothing but the stricture.

Three varieties of instruments for internal urethrotomy must be regarded as indispensable for good practice, viz: Civiale's, Maisonneuve's and Otis's. In skilful hands Civiale's urethrotome, a simple blade at the end of a delicate staff which may be projected or concealed at pleasure—is perfectly efficient; with it the Surgeon may cut just where he desires and as lightly or deeply as he pleases, he may direct its edge as Thompson observes, with all the certainty of a scalpel. Maisonneuve's urethrotome, especially with the aid of a whalebone guide, or of a flexible conductor screwed upon its tip, does excellent work. It is better adapted than any other form, cutting as it does from before backwards, (i.e. towards the bladder,) for the division of small strictures without previous dilatation. But as the blade must be passed,

from the meatus down the canal to the strictured point without concealment, it certainly must and does incise the urethra very extensively if the canal is much narrowed or naturally small, notwithstanding the blunting of the point of the blade which is designed to prevent such unnecessary though by no means dangerous incision. This very blunting of the knife however, as Sir Henry Thompson justly remarks, gravely impairs the value of the instrument for the section of the stricture itself. It is of the highest importance in the division of a stricture, that the extreme peripheral bands be cut through; the operation necessarily fails unless the whole thickness of the structure is divided. By thus blunting the edge of the little blade, that very part of it which naturally comes into relation with these peripheral bands fails to divide them and the other parts of the knife cutting properly, the blade is thrust through the stricture without dividing it quite to the healthy tissues; hence recontraction sooner or later. With Civiale's instrument, the surgeon alone is blameable, if these external bands are not divided, but the operator must have determined the exact locality of the stricture, and must possess great delicacy of touch, in order to accomplish his object without unnecessary injury to parts near by or underlying those he desires to divide.

In Otis' dilating urethrotome, we possess an instrument more easily used and more certain to secure the desired extent and accuracy of section than either of the preceding ones. The requisite amount of distension is attained by turning a screw in the handle, the degree of separation of the bars of the urethrotome being recorded and read off on a dial with a moving hand. By observing this, we know exactly the amount of separation of the bars. Division of the morbid structure is accomplished by the movements of a narrow knife which can be concealed at will, sliding in a groove hollowed out of one of the bars. By a proper use of the screw the stricture is

stretched and becomes so greatly attenuated upon the bar in contact with it, and also so firmly held that a single passage of the blade almost infallibly cuts it through and through. By additional turns of the screw, we may still further incise the parts to any extent desirable. In the earlier forms of Otis's instruments the apex of the knife was blunted as in Maissonneuve's, but the significance of Thompson's remarks on the subject seem to have been duly appreciated by Dr. Otis, for I find in the last modification of his urethrotome sent me from Tiemann, that there are two knives, one of them blunted, but the other quite sharp and slightly convex, in all respects similar to the little blade of Civale's instrument; I have lately used this blade with great satisfaction.

Otis's urethrotome is manufactured of several patterns; one of these is slightly curved, with the knife-blade travelling on the *concavity* of the curve; it is thus only adapted for section of the *roof* of the urethra. Another style is perfectly straight, an exquisite instrument which can be turned about in the urethra, and used for dividing any stricture whatever from the membranous junction with the bulb to the meatus, either towards the roof or towards the floor of the urethra. The introduction of this straight instrument requires more care than for the curved pattern, but is easily enough effected by any one used to introduce straight instruments into the bladder.

For the treatment of all strictures already somewhat dilated, *resilient* or of *large calibre*, this is certainly the most appropriate appliance. As we can steady the parts by screwing apart the bars, and may do this to the precise degree demanded by previous calculation of the proper size of the urethra in the locality of the stricture, and as the passage of the blade to and fro a little is certain to divide the tense structures thoroughly,—almost the *beau ideal* of a perfect urethrotome, seems to have been realized in this ingenious though expensive instrument. We may operate with it at the bulbo membran-

ous junction more easily and securely than with any other instrument, or we may divide strictures anterior to the scrotum, or at the meatus; indeed it is altogether superior as a meatotome to any other appliance, even the simple probe pointed bistoury itself, for it steadies the parts and enables the surgeon to divide them with absolute precision and great rapidity. A special pattern of Otis's instrument is designed to distend only a certain area of the urethra, without stretching the more distal or proximate portions of the canal—in accordance with the demands of the recognised physiology and anatomy of this important but roughly treated canal. The urethra is scarcely to be regarded "as a closed valvular chink" but rather as a chain of collapsed pouches or sinuses connected together by tubular openings whose walls are normally corrugated and in close contact with each other. Of these ampullar dilatations there are three, possessed of characteristic functions relating mostly to the extrusion of the seminal fluid, but in part to micturition, viz: the prostatic portion, the bulbous portion, and the *fossa navicularis*. Scientific surgery demands that all operations designed to restore the calibre of the canal shall be based upon an exact recognition of its *varying* diameter at different points. Nothing can be *cruder* than, to dilate a stricture at the bulb to the calibre of the *meatus only* as is usually done, while the diameter of this part is naturally about *twice* that of the meatus. Hence a fundamental objection, on the score of insufficiency and of consequent residual abnormality of the canal, to all methods of simple dilatation by bougies or sounds *alone*, and hence the immensely superior results attained by primary *section* with subsequent passage for a certain time, of very large sounds, the meatus being duly incised for their introduction. It is in this respect also, viz: in the pertinacity with which surgeons have insisted upon regarding the urethra as a tube of unvarying calibre, that Maissonenve's instru-

ment is theoretically and practically defective, for the blade is of unvarying width and the instrument cannot be expanded in the urethra according to the requirements of the locality operated upon.

Otis's instrument is especially applicable to the division of strictures of large calibre, so large that they have been generally overlooked by both patients and practitioners, and are still mostly neglected notwithstanding all that has been demonstrated of late with regard to their pernicious influences upon the urinary apparatus, and in a reflex way upon the system at large. *Every stricturing ring around the urethra should be divided, although a No.8 or No.10 sound (English) be passable with perfect ease.* These large strictures can only be made out by means of bulbous bougies, and in cases of gleet and obscure urinary or nervous trouble should be diligently sought for and promptly treated. It is but too common for the practitioner to dismiss his patient with the assurance he has *no stricture, because a No. 10 or even No. 12 (English) bougie can be easily passed—while trouble is coming ere long, or has already fallen heavily upon him.*

When a stricture is thoroughly divided by internal urethrotomy and subsequently dilated during the healing process, recontraction is less prone to occur than by any other method whatsoever. Otis indeed claims that after a month, when the parts are supposed to be quite healed the occasional use of the sound may be entirely dispensed with and a true radical cure anticipated. The judgment of time has not yet been passed upon these theoretical assertions, although it is certain that at present we must admit that *division with previous stretching* as by Otis's system, thoroughly carried out in minute accordance with his maxims, has given us cases where recontraction has been delayed up to date, and longer than by any other method where the sound has not been periodically introduced after the section.

Notwithstanding the vascularity of the divided tissues

haemorrhage is usually slight after internal urethrotomy, though sometimes rather profuse when the extent of the wound is considered : but it may be always readily controlled by cold and pressure against a full-sized sound introduced into the urethra.

Urethral fever likewise supervenes occasionally, but may be guarded against, to some extent, by preparation of the patient, and readily enough controlled by emetics or a smart purge, veratrum and quinine. Though occasionally very severe, I have never had any real difficulty in coping with it.

Subcutaneous urethrotomy, as applied to strictures mostly anterior to the scrotum which always require section in some form, as they do not bear dilatation well, may be viewed as a modification of internal urethrotomy. It is done after the manner of tenotomy. I confess it is difficult to recognise the indications for such a manœuvre when strictures may now be so perfectly divided from within the canal.

External perineal urethrotomy without a guide the proper "*Boutonniere*" operation, is now far less often demanded than formerly, in consequence of the great improvement in our methods and instrumental appliances for reaching the bladder through small strictures. A guide of some kind, in course of time, may be generally insinuated even though tortuous strictures, and matters thus rendered very much easier.

Syme's operation, into which all such cases are reduced, has been a good deal practised and must rank as very safe, and decidedly the most thorough cure for perineal stricture at our command. It is seldom resorted to now for mere stricture, unless this be of traumatic origin, notwithstanding Syme's advice and practice. It is properly reserved for cases gravely complicated with vesical, renal, or prostatic disease, and for certain intractable cases of chronic cystitis associated with spasmodic irritability of the muscles of the membranous and bulbous

urethra. A clear section through the bulb and partly into the membranous urethra, sometimes even up to the prostate, is wonderfully efficacious, and remarkably free from risk provided a free exit to the urine be provided by way of the urethra or the wound, which however cannot be trusted as it may close very early. We must adopt as a maxim therefore in Syme's operation, *to divide to the proper extent, all strictures or contractions of the urethra anterior to the one in the perineum operated upon, some days before, or at the time of operation itself.* For draining the bladder we do not now employ the catheter retained in the urethra as Syme formerly advised. This practice, is abandoned in America, and by leading practitioners in Europe; nothing but harm can ever come of it. Van Buren and Gouley are particularly urgent in its denunciation; Mr. Syme abandoned the use of the catheter throughout the whole extent of the urethra in his later operations, and substituted for it, a peculiar form of catheter traversing the *perineal* wound alone, and retained only *twenty-four hours.* Its object was to afford passage to the urine and to prevent obstruction by blood clots until a certain amount of agglutination of the tissues had been effected and the system thus saved from risk of infiltration of urine and its disastrous consequences. Erichsen advises (Edition of 1873) that the catheter be retained only for *forty-eight* hours after the operation; dilatation to be systematically practised, but not *beginn* until ten days after the operation.

The necessity for the subsequent passage of sounds of large calibre, at regular periods, must be admitted. Only in very rare cases, has recontraction failed to ensue upon a cessation of their introduction, and the disease to be re-established in as grave a form as at first. The introduction every week or two, or every month, by the patient himself, of a properly curved, well polished conical steel sound, is no great hardship, and is a better se-

curity against recurrence of the stricture than all other precautions put together; but the sound *should be as large as the urethra can be made to carry*, and should be seldom used without previous complete section of the stricture, by internal or external division. Indeed *without division*, dilatation cannot be carried very far, introduction even of a conical sound becoming painful and often aggravating the stricture ; it is at this point that section is indicated and proves so directly and remotely advantageous.

In a subsequent article I shall give the details of some cases of urethrotomy illustrative of the modes of practice advocated in the foregoing remarks.

1424 Washington Avenue.

Proceedings.

ST. LOUIS MEDICAL SOCIETY.

STENOGRAPHIC REPORT.

By ROBERT M. FUNKHOUSER, M. D. Reporting Secretary.

REVISED BY THE COMMITTEE ON DEBATES.

May 26th 1877.

Dr. Lutz, reported an interesting case of necrosis of the Femur, and presented the specimen before the society. He read the history of the case which was as follows: Central Necrosis of the Femur.—

J. Laetry a native of Maryland, and by occupation a farmer, was admitted into the Alexian Brother's Hospital, October 19th 1876.

He had been suffering from intermittent fever at intervals for several years. About one year ago, he exper-

ieenced considerable pain in his left thigh, and shortly afterwards noticed a discharge from its posterior portion (through two openings,) which varied in quantity. An examination revealed several scars in the cervical region; and a laxity of the articulations, especially of the left sterno-clavicular. The left knee-joint was ankylosed ; the femur thickened and two openings presented themselves, one at the apex of the popliteal space, which was the larger, and through which the probe entered perpendicularly and struck the roughened surface of the bone ; the other situated about eight inches higher up, was the exit of several sinuses, and through it the probe did not touch the bone. At this time he was suffering from chills and fever and was very much debilitated.

November 6th, the lower opening was enlarged by Dr. Gregory, so as to admit the finger down to the femur, when an opening was found in the bone, which was enlarged and several small pieces of necrosed bone were taken out. A sinus was found to extend along the shaft of the bone evidently reaching its entire length.

The patient apparently improved for several months, the discharge diminishing and his general appearance improving.

Shortly afterwards, however, he grew worse ; a troublesome cough, with muco-purulent expectoration set in, and the patient succumbed on March 16th 1877.

POST-MORTEM.—There was extreme emaciation, adhesions in both pleural cavities ; oedema of the lungs ; heart anaemic and its walls flabby. The ankylosis of the left knee joint was muscular and due to inflammation that had originated in the sheaths of the tendons. The inflammation, however, did not involve the joint. The left sterno-clavicular articulation had been opened and the sternal end of the clavicle was necrosed. Serofula was probably the cause of the necrosis. The necrosed femur was two inches longer than its fellow.

REMARKS.—You will see by examining this remark-

ably characteristic specimen, that the entire shaft of the femur is involved. It exhibits sinuses and internally a large sequestrum can be seen. At one point a portion of the bone has been chiseled out. The clavicle of this patient is also diseased. I will not attempt any more minute description of the specimen, which is such a remarkably fine one, that it speaks best for itself and will be better understood and appreciated by a careful examination.

Necrosis may result from periostitis or medullitis and it is especially liable to occur from inflammation of the medullary canal, because it is from this source that the bone receives in a great degree its nourishment.

Dr. J. T. Hodgen:—I would like to call attention to one point not referred to in the report just made, viz : that at the age of 17 years, the line of union of the epiphyseal ends, the condyles, the great trochanter and the lesser trochanter, with the bone is obliterated while the line of union of the head with the neck is not. This is an early period for the obliteration to take place and as a result, the limb would have been shorter if he had lived.

In children suffering from inflammation of bones, the bones are increased in length and thickness. As in the case of inflammation of the fibula when the fibula increases in length, becoming bent and presenting the appearance of a bow attached to the tibia which acts as the string. This should lead us to be careful about giving a decided opinion to the mother in regard to the length of the limb in future.

Dr. Prewitt then presented specimens of diseased kidneys and heart. The report of the case was read by the doctor, and has been published in the July number of the JOURNAL.

DOES DIPHTHERIA REOCUR?—(Dr. Pollak): I would like to ask the question, If second attacks of Diphtheria are frequent. I ask this question because I had a patient a boy nine years old who had an attack of diphth-

last February, and three months afterwards I was called to see him a second time for the same disease.

(Dr. Kennard): It does reoccur. I have seen cases of reoccurrence, but I do not remember of an instance of its having happened at so short an interval as Dr. Pollak mentions.

(The Pres., Dr Scott): I think this is a good opportunity to make some remarks in regard to the contagiousness of this disease, especially the length of time the liability to communication by contagion remains. In December last, three children had this disease and died.

The mother contracted it also. After the children died, their clothing was packed in a trunk. A month ago, in a visit to a sister, the mother of the dead children gave the trunk to her sister, who looked over the clothes in the trunk, shortly afterwards she had a bad attack of Diphtheria. She suffered with extreme prostration from the beginning, so that I had to use stimulants. The attack lasted two weeks, and she has scarcely recovered up to this time. In this instance there could be no doubt as to the origin of the disease, none whatever, and this makes it the more interesting.

June 2nd 1877.

A paper was read by Dr. Lutz, entitled Diastasis of the Sternum by the violent action of the diaphragm in coughing, (see JOURNAL, July 1877.)

(Dr. Gregory): I have an interesting case to report presenting a novel feature, viz: A protrusion of small intestine without a covering, in the groin (a) situated about the internal abdominal ring, midway of Poupart's ligament and one half inch above it. The history of the case is as follows: The patient was a woman 30 years of age, married eighteen months, but has not had a child. She consulted me a year ago for a swelling in the right iliac region. I thought it was the result of inflammation and

directed to be poulticed. Five or six weeks afterwards it became soft and pointed. It opened and pus exuded I enlarged the opening and a great quantity of pus came away. The inflammation continued to disappear. I saw no more of the wound for months, but being in the neighborhood I saw her again. She said that she was well, and she seemed to be in fair health. Two or three weeks ago I was summoned to see her and found her with high fever, anxious face, and an excited mental condition. She said that she thought she would not recover. This was a day or two before Sunday. In the morning of Sunday she got up and attended to her duties and even carried a bucket of coal from a coal yard near by. She walked ten blocks to church, whilst there she became sick and felt pain in the region of the opening but she thought she would feel better. Her sickness increased however and she left the church and hurried home. She told her husband, that she was sick and then went to bed. Some women who were neighbors, while arranging the bed-clothes, discovered a mass in the groin. Doctors were summoned. I was not at my office when they sent for me. Dr. Riley, arrived first, when I got there, I found a wound, sewed up and the general condition as stated ; the site of the ulcer was dripping with pus and continuous with it was the opening out of which the bowels had protruded. Dr. Riley said that he thought all of the intestines were out. They were rather purple, and from his description I judged they had been constricted. Failing to return them by manipulation he enlarged the opening so as to replace them and he did right in doing so. In the morning, there was some fever. In the evening fever, prostration with the reaction. As she had vomited and being afraid that she might have vomited up the morphine given by the mouth I gave her an hypodermic injection. The next day another injection was given, the symptoms being the same. On Tuesday, she succumbed, suffering all the time fever and symptoms of

peritonitis. I learned from her at the bed side that for several months the intestine came down and she was accustomed to push it back. The interesting feature about it was, that it escaped without any parietal sack, the rupture embracing the parietal peritoneum. How important it was that she should have worn a truss or compress for sometime after the closure of the opening in the first place. This is a practical lesson, teaching us that some artificial support is necessary in similar instances. She did not know the importance of it. No post-mortem was obtainable. This seemed a very unique case, certainly a novel one to me.

(Dr. Prewitt): I would like to make some remarks on the case reported by Dr. Gregory. I differ some what in the interpretation of the case. I take it to have been a pericecal abscess, from the description it presented the appearance of an abscess. The occurrence of the accident I would interpret differently. The first opening was already closed, and left a thin cicatrix, composed most probably of peritoneum some connective tissue and cuticle. I infer this was the condition from her statement that she was well, and suspect in carrying the weight mentioned, this thin wall gave way, the peritoneum as well. It was not a protrusion made by the abscess but by the actual rupture of the peritoneum and cicatrix, and the bowel was uncovered and it was not simply a fistulous opening. The intestine did not sooner pass out of the opening because it was prevented by a cicatrix. She meant perhaps, there was no discharge when she said she was well. These abscesses and pericecal inflammations bear an intimate relation to each other. One case I call to mind, a patient of mine, a lady who had two attacks of inflammation with short intervals between them in the ilio-caecal region. The first one was not so severe as the last, about a month or six weeks ago which was very severe. There was soreness, tenderness on pressure and pain on movement with

the temperature 102° I had great fears that an abscess would form. In these cases when the irritation or the causes producing the irritation are removed, the inflammation may subside, but it is liable to recur and an abscess form. It is a constant menacing danger when local inflammation has once occurred. If the patient has had one attack we should be apprehensive of a second:

(Dr. Gregory): I do not know the relation of the protrusion to the sinus. I learned that pus dribbled away and from the facts already stated, no doubt Dr. Prewitt is correct about some inflammatory products being present and preventing the intestine from protruding. In regard to the rupture without any parietal peritoneum, it tore right through on the day it occurred and appeared naked. And I never have been able to know how a hernia can occur without rupture of the peritoneum. I can readily understand it when the hernia is slowly forming and also how an oblique inguinal hernia may take place into the unclosed peritoneal sac but not how a sudden hernia can occur without rupture. I can understand when the hernia is gradual, also when it occurs in an adult into the vaginal process. This is more frequently open than we know. In this connection there is an interesting fact in regard to Sir Astley Cooper, in both of whose gonads, the vaginal processes were found open upon dissection, without their occurring during life. This fact is frequently noticed in dissecting.

June 9th 1877.

Dr. Dean presented a specimen of *echinococcus multilocularis* of the liver. He read the history of the case reported by Dr. Gardner of the Hospital as follows :

The name of the patient : Fred Mayer, age 39, occupation, blacksmith. Family history: Father is still living; Mother died of some acute lung trouble at the age

of 65. Rest of family living and healthy. Past History: Patient has previously been a healthy man. Had small-pox in 1872, had some stomach trouble in 1873, while working in a lead-factory, and was treated for lead-colic, says that he would go four or five days without an operation from his bowels and then would pass a great deal of blood in his stools. He felt well when his bowels were open—he has been a beer-drinker all his life—but not drank more than seven or eight glasses daily. No venereal disease. Present trouble began about October 1876. Patient then was working in a brewery, and would often go from a very warm to a very cold part of the building and thought that he caught cold at first. He had a cough and some difficulty in breathing. From this time until December, he suffered only from dullness and sleepiness in the day time, whilst at night he could not sleep. In December he first noticed swelling of the abdomen—had no pain until admission into the hospital. His feet began swelling in April last, and an eruption appeared on his legs in December. About May 1st 1877, he had a feeling as if something had given way in his stomach and immediately he vomited a large quantity of black blood mixed with mucus and the remains of undigested food. When admitted the patient was immensely swollen in his abdomen—the dullness in the region of his liver extended upwards as far as the *right-nipple*, and was palpable as far down as the umbilicus and nearly to the crest of the ileum. He was very much jaundiced, both of his lower limbs were swollen and oedematous. There was also effusion into the scrotum and cellular tissue of the abdomen. There was immense distention of veins upon the abdomen and all the veins of the trunk were varicose.

May 23d, patient called me to the ward. I found him suffering from intense pain and marked dyspnoea, and his abdomen was swollen and very tense. About 2 gallons of straw-colored serum was drawn off with the tro-

car, giving patient great relief. The opening remained patent until June 1st, when it closed, and the patient had to be again tapped and about one and a half gallons of serum was drawn off. Died June 4th at 3 A. M.

For the further consideration of this case see *Hospital Reports* in the August number of this JOURNAL.

On the subject of hernia, Dr. Gregory said that he had had in his practice, during the last week, four cases of incarcerated hernia, which is rather remarkable. The history of one case I have not. The history of another is involved in obscurity. The two others were old hernias, and it was due to some neglect that they had occurred. In one there was some pain and soreness in the site of the hernia. It has been my custom when called to a case of incarcerated hernia to administer chloroform first, and then to try taxis and what is remarkable I frequently fail to reduce the hernia and come back the next morning when the patient tells me it went back during the night. In the case referred to, the patient probably had been drinking beer and been indiscreet, and the hernia got down. He could not get it back and became anxious. I made little pressure and injected a little morphine under the skin ordered applications to the part and when he was rested I told the patient to work on it again. Having heard of strangulation, the wife was afraid, and asked what should they do if it grew worse. I tried to quiet her. I thought it would go back and trusted that the patient would succeed. However, I told them to send for me by 4 o'clock in the afternoon. A little after 4 o'clock they came and said it was no better. On my way, fearing that I might need some one I took an assistant along with me. He suggested to get some chloroform but I said no. Just as I entered the room the patient said, its back. Another case was from Caseyville, Illinois. Physicians had attempted to return it without success. A man came to my office and said he had a man outside in a buggy, with

an incarcerated hernia. I sent him to the hospital where I visited him and found he had a rupture. There was no fever, no anxious countenance. I learned that two physicians had tried to reduce it under chloroform but unsuccessfully. I ordered leeches to be applied to the neck of the sac, and gave internally opium. The patient felt comfortable, but the next morning *there* was the hernia. As we were going through the work Dr. Moses suggested to try and put it back. I tried and failed, and was apprehensive that the pressure might do harm. We gave the patient a dose of castor oil which acted nicely. Next morning the hernia was still there, it interfered more or less and was slightly tender. On the following day he left the hospital, the hernia unreduced. He wanted to go and could not be persuaded to remain. You can't do anything with some kind of patients. I was satisfied to keep him in bed, and felt that in time the hernia would cease to exist. It might go back and by suitable trusses and compresses the opening would become smaller and blocked up. I think it is a bad practice to try to return the hernia at once. It is better to apply leeches and administer anodynes and to wait. I have often failed to reduce hernias and would be afraid that in my next visit I would find bad symptoms. I believe there is no risk when there is no impediment in the circulation, when there is no pain and when no bad symptoms exist it is better to depend on position, leeches and administration of anodynes.

June 16th, 1876.

(Dr. Dickinson): I have an interesting case, the details of which I will briefly read: It is a case of hemiopia. After reading the history of the case the Doctor remarked: I would add, that I have since seen the patient. His distance of vision which was three and one half inches, now is fifteen inches. There is a degree of atrophy of

the part indicated but not to any great extent. He has recovered from the accompanying symptoms.

(Dr. Prewitt): what is the dose of the iodide you have been giving him?

(Dr. Dickinson): Fifteen grains, three times a day.

(Dr. Lutz): I suggest that Dr. Dean continue his remarks on the case of last Saturday night. It is a very interesting and a very rare one, and we would be pleased to hear anything he might have to say in regard to it.

(Dr. Dean): I said all that I had to, in the short time, half an hour, though perhaps very unintelligeably and I have nothing new to add.

(Dr. Prewitt): I would ask the Doctor, whether he has found any hooklets since?

(Dr. Dean): I have not had time since to examine, some of the physicians present took specimens of the liver, and if they have found any, I would be glad to hear from them.

(Dr. Prewitt): I got a specimen and examined the saes and found none of the hooklets.

(Dr. Dean): Very few are usually found in the saes though by perseverance they may be found.

Remarks were then made by Drs. Steele and Barker relative to the drainage of Chicago and comparing it with that of St. Louis. They were followed by Dr. Wm. Johnston on the same subject who referred to the relation of drainage to scarlet fever, diphtheria, small pox and eruptive fevers generally.

(Dr. Johnston): It is well known that the soil around Chicago is alluvial. It is well known that the water is drained by what is called the Chicago River, which empties into Lake Michigan. The ground on which Chicago is situated is level and is alluvial soil. For some time back Diphtheria and scarlet Fever have prevailed in Chicago. It is said that bad drainage is prolific of Diphtheria and scarlet Fever. Now is that a fact? It is well known that Philadelphia is a well drained city, and a

few years ago it was ravaged by Small Pox. Reasoning from comparison, if bad drainage causes scarlet Fever and Diphtheria, good drainage produces Small Pox. Does decomposition of vegetable matter produce scarlet Fever and Diphtheria. We know that scarlet Fever has been found in high and salubrious localities. It is not so well understood in regard to Diphtheria. The people in Chicago have fine water, better than we have. Then if by a rapid decomposition of vegetable matter there is produced a low form of organisms by spontaneous generation this is so in Chicago; according to the authority of Bastian and Hyrtl, who favor the theory from their experiments, while on the other hand the great scientist Tyndall denies it. So it is not proved in Chicago. Now, if decomposition of vegetable matter produces bacteria and culminates in scarlet Fever, if so then it is a truism that bad drainage produces scarlet Fever, and Diphtheria. This is not so. Burdon-Saunderson says they do, but he is not authority on spontaneous generation, which is not proven. We must notice the fact that other large cities well drained have out breaks not only of Scarlet Fever but also of Diphtheria and Variola. If they have Scarlet Fever in Chicago, why not here. Some other cause produces the eruptive diseases, de novo, if such fact could be established. If not they have existed in the human being as far back as the memory of men extends, whatever the cause may be, if it be in a suitable locality the disease will spread. Therefore it will not do to argue that if such be the case in Chicago, we are exempt. It has been only a few years since we have been so healthy. It may be that we have such talented and learned physicians that we banish the disease and send it to Chicago. We must not flatter ourselves. It takes years to demonstrate facts in regard to disease. Tho' I would not like to see Chicago, ahead, we can't say that Chicago is more unhealthy than we are. Years will demonstrate the fact whichever way it may be.

(Dr. Wm. Porter): Since there is so much time to spare I have a single thought to offer, for in our deliberations I am sure where syphilis, a magic word, is named, there will be found much to report on it. It is the hereditary form I have reference to and I wish to know whether my view is corroborated. I have noticed in cases of hereditary syphilis in addition to notched teeth, which are proofs positive, and the well known disease of the eye, that an increased height of the roof of the mouth is very common and believe that it is found in most cases. Dr. Langdon Down, of London, mentions it as occurring in the offspring of idiots and in idiots themselves. He found it in nearly every well-marked case. I ask the members to take note of this, and I intend to collect cases during the year. I called the attention of Dr. Green to it at the clinic who corroborates my observations. If this mal formation does occur in these cases; it may be of some importance in diagnois.

(Dr. Dickinson): As corroborative of, and without having seen the statement, made, my observations confirm it. I had a case a short time ago, where certainly the teeth were notched and the patient suffered with diseased eyes for years; there was deposit on the cornea which was hazy, there being interstitial inflammation of the cornea.

(Dr. Prewitt): I have had a conversation in regard to the subject with Dr. Porter previous to this meeting. Since then I have treated a case of a child in which there was an increased arch of the palate (hard).

Mr. Hutchinson does not claim that syphilitic teeth are constant. There may be cases where the notched teeth are wanting but still the patient has syphilis. He only claims that when present, they are strong additional proofs. There were no notched teeth in this case and no disease of the eye but she has hereditary syphilis. So also has her sister.

(The President Dr. Scott); What is your hypothesis, Doctor?

(Dr. Prewitt): Simply a modification of the arch. It may be in cases referred to, that syphilis is the origin idioey. It may in some way affect the structures and account for the structure for the high roof of the mouth. It is a modification of development. In the case of Dr. Dickinson which was reported to-night, the cause perhaps was syphilis. It might be said that he has not had symptoms for years if those mentioned be not symptoms. It is noticeable that when syphilis attacks the nervous system, the other tissues of the body are exempt to a great extent. It is a singular, but important fact. The only suggestion I have to make in Dr. Dickinson's case is to give a little larger dose of the iodide.

(Dr. Bryson): I will report a case which occurred some weeks ago during the spell of cold weather. I saw for the first time, a young man who was stout and healthy. Two years ago he contracted gonorrhea. He got perfectly well of it he says. About a day or two before he saw me, he was driving a wagon all day, during the cold weather sitting on a cushion upon which water collected. His testicle was exposed to the cold and in twenty-four hours perhaps less, he had a well marked case of epididymitis of the left testicle. At one time I thought the body of the testicle was involved. It appeared to be so, there being much hardness and swelling. But it was not; that peculiar sickening exerciating sensation, which follows pressure, being absent in this case. But the epididymitis was well marked. I examined thoroughly for a urethral discharge but there was none at all. The usual treatment was followed. He was placed on his back, poultices applied, a poultice of flax-seed and tobacco, half in half, which I have found very efficacious in such cases, and not by hypnotics. Perhaps thirty-two hours after, the epididymitis began to subside. Forty-eight hours afterwards a discharge from the urethra took place

When I first saw him there was very light tenderness, along the cords up the groin. Afterwards it became well-marked. In this case the inflammation or irritation had extended up to the urethra instead of downward.

In some manner the irritation extended to the vesiculae seminales. The discharge was not well-marked or persistent. I had not seen a case of this kind recorded till some time ago. I saw mention of some cases of Forneaure Jordan of England. Among them he reported cases of traumatic epididymitis with a discharge, the irritation passing up the urethra as well as downward.

Reviews and Bibliographical Notices.

THE PRACTITIONER'S REFERENCE Book. By Richard J. Dunglison, M. D., 8 vo. pp. 341. Philadelphia, Lindsay and Blackiston, 1877.

The introductory chapter—"The Hippocratic Oath"—is quite refreshing to one who has some knowledge of the profession *as it is*, in this country at this time. It will be noticed that the book is of respectable size to have at hand as a work for reference. The "pocket dose books" and "physician's prescription books" heretofore published look too much like the primer of the primary schools, one don't care to refer to them in the presence of patients who are apt to think a physician should carry in mind the contents of so insignificant a book. This work supplies a most important want in its concise condensed and alphabetically arranged chapter, on the *doses* of medicines; considering the age, physical condition &c. By the stomach, and hypodermically. As arranged in our works on *materia medica* and *therapeutics*, it takes too much time to look over a page or perhaps several pages before you come up with the dose.

Under the head of *General Information* for the practitioner, we have first *Weights and Measures*, of the United States. Pharmacopœia weights and measures of the Metrical System. Relation of weights of the United States Pharmacopœia to Metrical Weights.

Approximate conversion of ordinary measures into Gramme Weights (Metric System). Number of Drops in a fluid-drachm, variations of different fluids, and consequent upon the vehicle dropped from, whether a bottle or minim measure. The relative value of the drop and minim. Approximate measurements.

Solubility of Medicines in Water, Alcohol, Ether, Glycerine, etc. Abbreviations in common use. Then follow a table of *Doses of Remedies in General*, Alphabetically arranged. A table of *Maximum Doses*. Doses of Medicines administered Hypodermically. Doses of atomised fluids for inhalation, for injection, in the urethra, vagina; for suppositories, enemata; how to medicate baths, etc., etc. Brief rules for clinical examination of the urine. Exact directions to conduct a *post mortem* examination concluding with an Addendum of *New Remedies*, indexed alphabetically.

Comparative digestibility of animal substances, also of vegetables, as regards their dietetic value for the sick. A chapter or section on the Dietetic preparations for the sick. The book is printed with clear type on good paper, and has our unqualified commendation.

The profession cannot fail to appreciate the work, as a compilation of most important information for the practitioner, so conveniently arranged and carefully tabulated, as to save a vast amount of time.

E.

NON-EMETIC USE OF IPECACUANHA, by Alfred A. Wood-hull M. D., Assistant Surgeon U. S. A. pp. 155. J. B. Lippincott & Co. 1876.

This little work is for the most part compiled from reports made by the author to the Surgeon General with some additions as to theory. The first seventy-five pa-

ges contain many interesting facts relating to the use of large doses of ipecac in gastric and intestinal affections, in neuralgia, pneumonia, acute hepatitis, and other important diseases. The proposition is that the drug is a direct nerve stimulant, acting upon the sympathetic system, though this has been heretofore overshadowed by placing ipecac among the emetics. The author sustains his argument by clinical facts and is unsparing in citing authorities upon the subject. Twenty grain doses, with or without opium, seem to be used unhesitatingly in the practice of Dr. Woodhull, and if the favorable cases reported are in fair proportion to cases in which the treatment may have failed, which in a book of this kind it is not customary to mention, the author is justified in his enthusiasm and this is a step in advance of the general line of march followed by the profession. It is well known by many physicians that Dover's powder may be given in larger doses than those mentioned in the text-books, with perfect safety, and often with good result in diseases of the intestinal mucous-membrane. These will recognize in this work, special merit. To others we commend the book on general principles as being closely written, clear, and containing much of interest and profit. It is well worth a careful reading.

W. P.

Books and Pamphlets Received.

NAPHEY'S THERAPEUTICS, a new edition (the fifth) we have notice is in active preparation. The edition published a few months ago being *entirely exhausted*, a most substantial and earnest endorsement, by the Profession of the excellency of the work.

AIKEN AS A HEALTH STATION; By W. H. Geddings, M. D., of Aiken, South Carolina.

EPITHELIOMA PENIS OPERATIONS; By Christopher Johnson, M. D.

THE TONER LECTURES No. V.; By William W. Keen, M. D., Smithsonian Institution, Washington D. C.

MEDICAL REFORM; By David Hunt, M. D., Boston. A. Williams & Co., New York, A. Wood & Co. 1877.

VERATRUM VIRIDE. ITS PHYSIOLOGICAL EFFECTS, AND THERAPEUTIC USES. By Jno. S. Lynch, M. D., Baltimore. Innes & Co., Printers, 1877.

THE RELATIONS EXISTING BETWEEN ECZEMA AND PSORIASIS; By Robert Campbell, M. D., New York. G. P. Putnam's Sons, 1877.

MECHANICAL PROTECTION FOR THE VIOLENT INSANE; By Engine Grissom, M. D., LL. D.

BIOGRAPHICAL SKETCH OF BARON CUVIER; By A. J. Howe, M. D.

CHOLERA INFANTUM, TREATMENT OF THE COLD STAGE; By E. T. Wells, M. D.

THE PHYSIOLOGY OF SUGAR, IN RELATION TO THE BLOOD; By F. W. Pavy, M. D., F. R. S.

A SIMPLE MODE OF CLEANSING THE NASAL AND PHARYNCEO-NASAL PASSAGE. By Thomas F. Rumbold, M. D. Removal of Hardened Secretions from the nasal passages. By Thos. F. Rumbold, M. D.

FAT AND BLOOD, AND HOW TO MAKE THEM. By S. Weir Mitchell, M. D., Philadelphia. J. B. Lippincott & Co. 1877. 12 mo. pp 97.

(For sale by the St. Louis Book and News Co.)

THE AMERICAN MEDICAL ASSOCIATION AND THE UNITED STATES PHARMACOPEIA. A Reprint of the Pamphlets of Dr. H. C. Wood, Mr. Alford B. Taylor, the Philadelphia County Medical Society, and the National College of Pharmacy with a Rejoinder addressed to the Profession of Medicine and Pharmacy of the United States. By Edward R. Squibb, M. D.

Extracts of Current Medical Literature.

Veratrum Viride.

At the close of an article by John S. Lynch M.D. on the physiological effects and therapeutic uses of Veratrum Viride the author thus summarizes the advantages which this medicine possesses over Digitalis 1st, its greater certainty and rapidity of action; 2d, the smallness of the dose; 3d, shorter duration of its effects; 4th, entire absence of narcotic effect; and lastly, its complete controllability both in its emetic and arterial sedative effects by opium and alcohol. For all the purposes, therefore, for which an arterial sedative is desired, whether to meet a suddenly occurring emergency, or to combat a persisting pathological condition, I believe that Veratrum possesses many advantages over all other arterial sedatives, including blood-letting, digitalis, and aconite; and I invite the profession to try it again, and to give it, by a continued conscientious and painstaking observation, a fair chance to demonstrate its most certain, swift, pleasant, and effectual power in controlling all diseased conditions in which excessive action of the heart is either a consequence or an incidence, as well as all effects or symptoms of disease whose removal would be promoted by slowing the circulation and diminishing venous congestion.—*Trans. Medical and Chirurg. Soc. Maryland.*

Treatment of Eruption from Rhus Toxicodendron.

In the LOUISVILLE MED. NEWS of the 15th of July, 1876, Prof. L. P. Yandell, Jr., recommended upon experience the use of corrosive sublimate and quinine as a remedy for poison-oak eruption. Since that time I have given the remedy a fair trial, with the happiest results. There is living in this vicinity a young lady who is extremely susceptible to the effects of the *rhus toxicodendron*. I have in this case previously tried various remedies, but to no avail; the disease pursuing a regular course quite regardless of therapeutical measures. This spring she again applied to me for treatment. Her face and arms

were badly swollen; so much so that her most intimate friends would scarcely have recognized her. I ordered a two-grain solution of corrosive sublimate to be applied to the inflamed surface thrice daily; also twenty grains of quinine, in divided doses, to be taken at regular intervals. I saw the patient about twenty-four hours afterward, and on examination found the inflammation giving away rapidly, and at the end of forty-eight hours it had entirely subsided. I have not tried the corrosive sublimate or the quinine separately.—DR. VAN WYE
Louisville Medical News August 1877.

The Cold Bath In Infantile Diarrhea.

This has long been known as a most efficacious measure, even in extremis. An Italian practitioner, Dr. Wocke, has lately been drawing attention to the same plan of treatment. He refers more particularly to the terrible epidemics of diarrhoea which prevail in summer.

The epidemic is due, he says, in part to the deleterious influence of the elevated temperature on the infantile organism, and in part to the injurious effect which the heat exerts on the aliment, the milk, and the air inspired. For this state of things he recommends cold bathing, of which he has a high opinion. Wasting children, reduced by vomiting and diarrhoea, were as if regenerated by the second day after the baths were commenced. The restlessness disappeared; sleep was restored, the appetite increased, and the diarrhoea diminished.

The cold baths act on the child as a tonic, and internal remedies then exert a better influence. Dr. Wocke commences his treatment with cold douches to the head and stomach; then passes to baths, commencing at a temperature of 26° C., reducing them 22° . Three baths a day are sufficient. [Med. and Surg. Report.]

Carbolic Acid In Diarrhea.

A correspondent, Dr. J. W. Palmer, of Ohio, writes us:—Recently, I have employed carbolic acid in the treat-

ment of diarrhoea, both acute and chronic form of the disease, with signal success. It is given in one or two drop doses, largely diluted with water, from two to four hours apart. It controls pain, and corrects the fetor of the discharges, and otherwise cures the disease. If severe pain be present, and the discharges profuse, opium and creta preparata, with astringents, may be alternated with it. But my experience is that carbolic acid in most cases is all that is required. [Med. and Surg. Report]

The Vegetable Origin Of Malaria.

Dr. Salisbury, of Ohio some years ago claimed to have discovered the microscopic vegetation which produces malarial disease. Recently, two Italian physicians, Signori Lanzi and Terrigi (*Monthly Microscopic Journal*), have discovered minute dark granules belonging to Cohn's group of pigmented sphaero-bacteria within the endochrome of algae, which increase in number with decay of the latter. These granules yield on cultivation the *Monilia penicillata* of Fries, and are identical with the pigment granules of the liver, spleen, and blood of those who have suffered from malarial diseases. Lanzi has even obtained a *Zoogla* by cultivation of these granules from a human liver. On the evaporation of the marshy pools of the campagna in summer, great sheets of decomposing algae are exposed to the air, the sphaero-bacteria abound, and are found floating in vast numbers in the atmosphere, to the height of fifty centimetres above the level of the marsh.—*Med. and Surg. Report.*

Value Of Eucalyptus.—In his *Clinical Studies*, Sir John Rose Cormack makes some remarks upon a therapeutical agent, but little known in this country, viz; The eucalyptus globulus. In simple uterine catarrh, he says that he does not know of any remedy equal in value to preparations, of the plant. "In such cases" he continues, "I have several times, with most satisfactory results, simultaneously administered them by the

stomach and in the form of injections. As Gubler has shown, the anti-catarrhal virtues of eucalyptus are most remarkable. With increasing experience of its power, I more and more employ it in bronchial, vesical, and uterine catarrh, in gonorrhœa, and in gleet." An infusion—one-half ounce to two pints—or a tincture—one ounce to one pint of rectified spirits—of the leaves, or the essential oil given in capsules, are the preparations ordinarily employed. As a gargle or vaginal injection, and for external application, the infusion, or tincture diluted—one drachm to six or eight ounces of cold or tepid water—may be used. Besides these therapeutic uses of eucalyptus, the author adds his very favorable experience of its remarkable power of destroying the fetid odor of morbid discharges *without the substitution of another unpleasant smell*. He speaks from an extensive trial of eucalyptus lotions in horribly offensive discharges in cases of ozaena, cancer of the tongue and throat, cancer of the uterus, gangrene, and other affections attended by fetor.—[*Toledo Medical and Surgical Journal.*]

Corrosive Sublimate Formed In A Mixture of Calomel and Sugar.—When Colomel comes in contact with powdered white sugar, or calcined magnesia, a certain quantity of corrosive sublimate is formed in twenty-four hours. Dr. Polk has observed all the phenomena of corrosive sublimate poisoning produced by the administration of a mixture of calomel and sugar, which had been prepared for a month. The examination of a portion of this mixture proved the presence of a notable quantity of bichloride of mercury. In the *Journal of Pharmacy and Chemistry* of Turin, November, 1875, the same fact is noticed. In this case the poisoning was caused by the pastils containing calomel. The pastils were made with sugar, which acted as an organic matter on the calomel, and transformed it into bichloride of mercury. The pro-

portion of the sublimate increases with the period passed since the preparation of the pastils. — *Observatore Md. Siciliano. Ohio Med. Rec.*

Automatic Reduction Of Luxation Of The Head Of The Femur.—In the July number of the New York *Medical journal*, Dr. A. B. Crosby described a case of automatic reduction of luxation of the head of the femur, which he accomplished by means of a method practised by Dr. Allen of Vermont. The method consisted in flexing both legs at right angles to the thighs, and both thighs at right angles to the abdomen. When in this position, the operator, by means of hands placed beneath the knees, lifted the patient off the bed and by gradually swinging him from side to side the dislocated head of the femur slipped into the acetabulum. Dr. Allen devised the method accidentally, in the following way: He was lifting a patient from one side of the bed to the other and while holding him until the clothing was arranged, the bone slipped into the acetabulum. [*Maryland Medical Journal.*]

Capillary Drainage In Anasarca.—Dr. Southey described to the Clinical Society of London, at their meeting April 27th, his method of drainage in general anasarca. He uses silver canulae about the size of hypodermic needles, and attaches to them, after introduction, a capillary rubber tube conducted into a pan beneath the bed. A surprising amount of serous fluid, he had found could be withdrawn from a single tube in each leg. The method is cleanly and free from discomfort to the patient. —*Maryland Medical Journal.*

Judications For Opium And For Digitalis In Asystolism In Various Diseases Of The Heart.

Two patients in M. Gubler's ward presented,—the one a good example of the efficacy of opium in asystolism in certain diseases of the heart, especially when the lesion is situated in the orifice; and the other a specimen of the cases in which opium would rather be pernicious, whilst

the preparations of digitalis have been found to answer very well. (We omit the narration of the cases, being merely typical examples—the one of double aortic affection, the other mitral regurgitant.) The conclusion deduced is: "Thus opium would rather be pernicious in mitral affections of the heart, whilst it is often useful in disease of the aortic orifice. Dr. Huchard, who was first to publish these facts in the *Journal de Therapeutique*, has invented a rather ingenious theory to explain them. According to him, opium produces congestion of the nervous centres, and digitalis, on the contrary, produces a local anaemia of them. But asystolism may occur in two opposite ways: Either from defects of nervous incitation of the pneumogastries, the result of an insufficient supply of the nutritive and exciting fluid to the supply of the encephalon, or, on the contrary, from what the ancients would have called *oppressio virium*. In aortic lesion, whether consisting in stenosis, or in insufficiency, the arterial circulation becomes enfeebled, and the various organs, at the same time, receive less red blood: this then is the case for the employment of opium, which increases the supply of blood to the brain."

In mitral lesions, on the other hand, it is the return of venous blood which is interfered with; the viscera, and notably the encephalon, are full of it. Digitalis ought to succeed.—*Gazette des Hôpitaux, Canada Journal*

Treatment of Acne.—Chantry (*Lyon Med.*, June, 1876) gives with benefit iodide of sulphur in the severer forms of rosacea acne. He gives it in pills, each containing 0.03 (gr. ss.) iodide, and 0.12 (gr. ij) ducamaran.

Locally he uses,

R	GRAMMES.
Potassae sulphide.....	
Tinct. benzoin.....	aa 4 (5i.)
Aqua.....	100. (5ii. ss.) M
A dessert spoonful is added to a glass of warm water	

and applied twice a day. (We have seen decided benefit follow the internal use of iodide of sulphur on indurate acne, but have rarely been able to employ it in doses exceeding 0-0001 (gr. 1-10—1-6) without producing gastric disturbance. Externally in the form of ointment it has been used for many years.

Functisons of the Liver.

In a paper to the Paris Academy of Science, Dr. Claude Bernard contributed some new researches on the sugar-forming theory of the liver, and concluded:—

1st. That the glycogenic property is inherent in the tissue of the liver,

2d. That this property manifests itself during life, and a certain time after death,

In the *Philadelphia Medical Times* of May 26th will be found an elaborate account by Dr. Lautenbach, of the results derivable from 283 experiments performed by him in Professor Schiff's laboratory, and leading to these conclusions:—1. The liver has for one of its functions the office of destroying certain of the organic poisons. 2. A poison is being constantly formed in the system of every animal, which it is the office of the liver to destroy.

On the Treatment of Eclampsia.

Dr Charles (*Memoirs of the Belgian Academy of Medicine*, 1876) sums up as follows the treatment of eclampsia, in his memoir on the convulsions of parturient women which was crowned by the Belgian Academy of Medicine.

1. Mechanical eclampsia from the sixth to the ninth month: (a) bleeding, if the case be urgent, or if there be true or apparent plethora; (b) drastics, in all cases, which may be more or less replaced by diaphoresis; (c) chloroform when the fits are about to commence and during the clonic convulsions; (d) chloral in the intervals of the attacks as an injection to beneficially fill the place of narcotics; any antispasmodic, such as bromide of potassium may be added to it; (e) to finish the delivery if pos-

sible; bring on the labour, if the fits do not show signs of disappearing; to bring on forced delivery in very serious cases: 2. Reflex eclampsia before six months gestation and after delivery;(a) bleeding is but very rarely indicated; (b) purgatives are somewhat useful; (c)chloroform, chloral,etc. should be continued as in mechanical eclampsia; and antispasmodics should not be neglected. 3. Toxic eclampsia. Fulfil the symptomatic indications; general or local bleedings to combat congestion of the brain and spinal cord when it is very marked; cold applications to the head, purgatives, diaphoretics, baths, revulsives, narcotics, anaesthetics, etc.—*Lond. Med. Record*, July 15, 1877.

The Opium Eater.—The confirmed opium-eater in the East seldom lives beyond the age of forty, and may be recognized at a glance by his trembling steps and curved spine, his sunken, glassy eyes and sallow, withered features. The muscles, too, of his neck and fingers often become contracted. Yet incurring even this penalty will enable him to indulge his voice only for a certain length of time. Unlike the healthy enjoyment which we derive from our appetite of hunger, and which nature herself renews periodically, the enjoyment of the opium-eater gradually diminishes as his system becomes habituated to the drug. From time to time he must increase the quantity which he takes, but at length no increase will produce any effect. Under these circumstances he has recourse to a dangerous expedient; he mixes a small quantity of corrosive sublimate with the opium, the influence of which is thus for a time renewed. Then these means also fail; when the victim must bear the miserable condition to which he is reduced, until probably, sooner, or later, he sinks into the grave. On the excitable temperament of the Malays and Javanese, a strong dose of opium causes a state of frantic fury amounting almost to madness, and this often ends in that homicidal mania which has been called “running amuck;” in other

words, in the individual attacking with his crease or dagger every one whom he meets, so that it becomes necessary to shoot him down with as little compunction as we do a mad dog. In Java, opium is not allowed to be sold except in an adulterated form, from the risk of these evil consequences being thus in some measure lessened.—*Pop. Sci. Monthly.*

Miscellany.

Dr. Sayre seems from all accounts, to be having quite an ovation among our British Cousins; and probably no American surgeon ever before received such marked attention on their part.

The *Lancet*, for July 14th, announces his arrival in London, and offers him a cordial greeting, and in the issue for July 21st gives an extended account of the principal points insisted on by Dr. Sayre "in his forcible expositions of the pathology, diagnosis, and treatment of spinal curvature." All the late numbers of the *British Medical Journal* contain references to his visit. That for July 14th, in speaking of his demonstration at University College Hospital gives the details of his method of treatment of Pott's disease and lateral curvature, and those for July 21st and July 28th contain reports of his demonstration at St. Bartholomew's and Guy's Hospital respectively.

His first demonstration of his method in London was at University College Hospital by invitation of the Surgical staff, before an immense audience.

Tuesday July 17th, he delivered a clinical lecture at St. Bartholomew's Hospital, on the invitation of Mr. Calender; and the same week he also appeared at the London Hospital. Wednesday, July 25th, he visited Guy's Hospital, by invitation of Mr. Durham, "put up" two

cases of Pott's disease and one of lateral curvature, before a large number of the profession. The first of the cases of Pott's disease was the daughter of Dr. Gooding of Cheltenham, and the second a child of eleven, who had never stood, and the worst case. Dr. Sayre said which he had ever seen. In less than half an hour he had the satisfaction of making her walk, which, of course, created the greatest enthusiasm among the audience.

On the day following, he "put up" four cases at the Royal Orthopaedic Hospital, of which he had previously had photographs taken.

Dr. Sayre then made a visit to Birmingham, at the request of the branch of the British Medical Association located there, and by invitation of Mr. West, senior surgeon, gave a demonstration in the amphitheatre of the Queen's Hospital, which was crowded to its utmost capacity. He lectured for one hour, during the course of which the plaster jacket was applied to two cases of Pott's disease, and one of lateral curvature, and at its conclusion Mr. West made a fine address, and moved a "hearty welcome and thanks to the great American surgeon."

The sequel is thus described by an eye witness: "Mr. Furnieux Jordan seconded the motion, with such a glowing tribute, and in such fervid eloquence, that Dr. Sayre became completely overcome. He spoke of the millions of human sufferers, heretofore tortured by rack and screw, and even then left miserable and misshapen, which would now be made easy and comfortable, and restored to perfect health and perfect form. He thanked God that the days of the hunchback had passed away, and that the instruments of torture would never be resorted to. At the conclusion of his remarks there was not a dry eye in the house, and there probably never was such a scene in any medical meeting before. Tears of gratitude got the better of Dr. Sayre's ability to speak, and he broke down completely in his first attempts to respond.

In a few minutes, however, he sufficiently recovered

himself to express his appreciation of the sentiments just uttered, and shortly afterward so electrified the audience with his own enthusiasm that one would have thought the roof would go off the amphitheatre."

On the 6th of August Dr. Sayre was to go to Manchester to be present, as a delegate from the United States, at the annual meeting of the British Medical Association; after which he expected to devote himself for a time to preparation of a work on the treatment of spinal disease, which will be immediately put in press by Messrs. Smith, Elder & Co., of London. During his stay in England he has been the recipient of much generous hospitality. Among the pleasantest of the entertainments which he has attended were a delightful breakfast, attended by all the principal men of the place, which Mr. West gave him at Birmingham, and a magnificent dinner in the Royal Hall of St. Bartholomew's Hospital, at which there were nearly four hundred guests present.—*Med. and Surg. Reporter.*

The St. Louis Medical College Edifice.

One of the land marks in St. Louis for a quarter of a century or more. Yet in architectural design, superior to many more modern public buildings. While on the exterior of the building it was only necessary to restore the wear from time, the interior of the building required thorough and radical reconstruction to systematize and harmonize the various appointments to aid the teacher, at the same time add to the comfort and success of learner.

To this end the front section of the building (formerly divided into lecture room and amphitheatre,) has been divided into three halls, that on the first floor for teaching chemistry and physiology, with laboratory and rooms for work in the rear. The hall in the second story of same size, with properly raised floor and seated with modern iron frame chairs, comfortably upholstered to the number of 325, (more medical students than any college should have) to the rear of this hall is the college library.

In the third story the amphitheatre is finished in the most approved manner, for students to witness operations and dissections on the table of the lecturer. The instruments and material being kept in dissecting rooms in the rear. The new stairways being relieved by landings and platforms, are easier of ascent; the entire building will hereafter be heated by steam. Nothing seems to have been omitted that a careful study of the comfort and health of the student could suggest.

Homer Judd, M. D., D. D. S, resumes the editorial of the Missouri Dental Journal, assisted by W. H. Eames D. D. S. The Dental profession will welcome these names to the title page of the journal, which they graced so worthily and profitably for many years.

Dr. Joseph D. Bryan has been appointed lecturer on general descriptive and Surgical Anatomy, at Bellevue Medical College, in place of the late Prof. A. B. Crosby.

E.

To Subscribers.

We are sorry to be under the necessity of reminding some of our friends of their neglect to remit the amount of their subscriptions, we trust the bills sent with this issue will receive prompt attention.

Newspaper Law Decisions.

1. Any person who takes a paper regularly from the post-office—whether directed to his name or another's or whether he has subscribed or not—is responsible for the payment.
2. If a person orders his paper discontinued, he must pay all arrearages, or the publisher may continue to send it until payment is made, and collect the whole amount, whether the paper is taken from the office or not.
3. The courts have decided that refusing to take newspapers or periodicals from the post office, or removing and leaving them uncalled for, is *prima facie* evidence of intentional fraud.

Meteorological Observations.

By A. WISLIZENUS, M.D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in the night, the maximum at 3 p.m. The monthly mean of the daily minima and maxima added and divided by 2, gives quite a reliable mean of the monthly temperature.

THERMOMETER FAHRENHEIT—AUGUST, 1877.

Day of Month.	Minimum.	Maximum.	Day of Month.	Minimum.	Maximum.
1	70.0	86.5	18	65.0	86.0
2	74.5	92.5	19	66.5	84.0
3	68.0	86.5	20	68.5	90.0
4	67.5	86.0	21	70.0	85.0
5	65.0	86.5	22	64.5	67.5
6	71.0	76.0	23	62.0	74.5
7	68.0	88.5	24	59.0	80.5
8	66.0	89.5	25	63.5	83.0
9	63.5	83.0	26	67.0	89.0
10	64.0	84.0	27	72.0	93.5
11	74.0	82.5	28	72.0	92.5
12	72.0	82.0	29	74.5	94.5
13	67.5	83.0	30	74.5	95.5
14	62.0	77.0	31	69.0	94.0
15	62.0	82.0			
16	63.0	83.5	Means	67.4	85.3
17	64.5	86.0	Monthly Mean	76.3	

Quantity of rain: 2.82 inches.

Mortality Report.—City of St. Louis.

From July 21, 1877, to August 28, 1877, inclusive.

Chol. Infantum..	78	Abscess Lumbar...	1	Valv. Dis. of Heart	8	Spina Bifida	1
" Morbus.....	5	Hydrocephalus...	7	Asthma.....	2	Abortion.....	1
Diarrhoea.....	14	Phthisis Pulmoni..	63	Bronchitis.....	1	Haemorrhage. Post-	
Dysentery.....	26	Scofula.....	3	Cong. of Lungs.....	4	Partum.....	1
Enterico-Collitis..	16	Tabes Mesenterica..	2	Fimphysema.....	3	Atrophy.....	3
Frysipelas.....	3	Tub. Laryngitis...	1	Haemoptysis.....	4	Astermia.....	2
Crauj.....	1	" Bronchitis....	1	Larvngitis.....	1	Gangrene (Senile)	2
Diphtheria.....	7	" Enteritis....	1	Pneumonia.....	11	Debility.....	14
Fever. Congestive..	18	" Meningitis....	1	Ascites.....	1	Pneum. ral Fever...	1
" Cerebro-Spinal ..	3	Apoplexy (Serous) ..	4	Colic (Bilious)....	1	" Convulsions ..	1
" Intermittent..	8	Cong. of Brain....	2	Enteritis.....	2	" Mania.....	1
" Remittent..	3	Cong. of Brain....	26	Gastro-Enteritis...	12	Burned.....	4
" Scarlet.....	2	Convulsions (Infan-		Gastritis.....	1	Fracture of Skull...	5
" Typhoid.....	18	tile).....	54	Intussusception...	1	Concussion of brain	4
" Typho-Malariai..	6	Dementia (Chronic) ..	1	Peritonitis.....	2	Drowned, accid'tal	9
" Typhus.....	1	Inflammation of		Cirrhosis of Liver..	7	Poisoning.....	1
Whooping Cough..	5	Brain.....	6	Congestion Liver...	2	Shock from Fall...	2
Congest Chills.....	2	Meningitis.....	34	Hepatitis.....	5	Homicide by Stab-	
Syphilis. (Tertiary) ..	3	Progressive Loco-		Hernia (Strangulated) ..	1	bing.....	1
" Congenital..	1	motor Ataxia...	1	Albiminuria.....	3	Hanging.....	2
Alcoholism ..	1	Paralysis....	2	Cystitis.....	1	Gunshot.....	2
Inanition.....	9	Hemiplegia.....	2	Haemorrhage of		Drowning.....	2
Purpura Haemorpha-		Sottening of Brain..	3	Kidney.....	1	Poisoned.....	2
gica.....		Tetanus.....	6	Nephritis.....	6	Total Deaths ..	775
Anæmia ..		Trismus Na-cen'm'.	20	Uraemia.....	2	Under five years ..	395
Anasarca.....	5	Atgina Pectoris...	1	Necrosis.....	1	Stillborn.....	48
Cancer. Liver ..		Dropsy.....	3	Rachitis.....	1	Premature Birth ..	18
" Breast.....		Embolism(cerebral) ..	1	Atelectasis Pulmo-			
" Intestines ..		Endocarditis...	1	num.....	2		
" Ovary.....		Fatty Degeneration ..	1	Congenital Defor..	3		
" Womb.....		of Heart	2	" Debility ..	1		
" Stomach.....		Heart-fiot ..	2	Infantile Debility ..	1		
Cancerous Cachexia ..		Disease of Heart ..	2	Cyanosis.....	2		
Marasmus.....	37			Uterus Neonatorium	1		

CHAS. W. FRANCIS, Health Commissioner.

WYETH'S DIALYSED IRON.⁸

(*FERRUM DIALYSATUM.*)

*A Pure Neutral Solution of Peroxide of Iron in the Colloid Form.
The Result of Endosmosis and Diffusion with Distilled Water.*

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This article posse~~s~~s great advantages over every other ferruginous preparation heretofore introduced, as it is a solution of Iron in as nearly as possible the form in which it exists in the blood. It is a preparation of invariable strength and purity, obtained by process of dialysis, the Iron being separated from its combinations by endosmosis according to the law of diffusion of liquids. It has no styptic taste, does not blacken the teeth, disturb the stomach, or constipate the bowels.

It affords, therefore, the **VERY BEST** mode of administering

IRON

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The advantages claimed for this form of Iron are due to the absence of the free acid, which is dependant upon the perfect dialysation of the solution. The samples of German and French Liquor Ferri Oxidi Dialys., which we have examined, give acid reaction to test paper. If the dialysation is continued sufficiently long, it should be tasteless and neutral.

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Articles intended for publication in the next number should be forwarded one month prior to the date of publication. They must be contributed to this Journal exclusively.

All communications, letters, remittances, books for review, etc., should be directed to
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The Thirty first annual session of Starling Medical College will begin Thursday October 4th, 1877, and continue until March 1st 1878. The preliminary course will begin September 4th, and continue four weeks. The College building is not surpassed in beauty and convenience and is well furnished with the requisites for thorough instruction including Laboratory, Anatomical Room, Museum, Library Reading Room, Microscopes, Instruments, Charts etc.

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The Collegiate Year in this Institution embraces a preliminary Autumnal Term, the Regular Winter Session, and a Spring session.

The Preliminary Autumnal Term for 1877-1878 will open on Wednesday, September 19, 1877, and continue until the opening of the Regular Session. During this term, instruction, consisting of didactic lectures on special subjects and daily clinical lectures, will be given, as heretofore, by the entire Faculty. Students expecting to attend the Regular Session are strongly recommended to attend the Preliminary Term, but attendance during the latter is not required. During the Preliminary Term, clinical and didactic lectures will be given in precisely the same number and order as in the Regular Session.

The Regular Session will commence on Wednesday, October 3, 1877, and end about the 1st of March, 1878.

FACULTY.

ISAAC H. TAYLOR, M. D.

Emeritus Professor of obstetric and Diseases of Woman, and President of the Faculty.

JAMES R. WOOD, M. D., LL. D.,

Emeritus Prof. of Surgery.

FORDYCE BARKER, M. D.

Professor of Clinical Midwifery and Diseases of Women.

AUSTIN FLINT, M. D.,

Professor of the Principles and Practice of Medicine and Clinical Medicine.

W. H. VAN BUREN, M. D.,

Professor of Principles and Practice of Surgery, Diseases of Genito-Urinary System, and Clinical Surgery.

LEWIS A. SAYRE, M. D.,

Professor of Orthopaedic Surgery, Fractures and Dislocations, and Clinical Surgery.

ALEXANDER B. MOTT, M. D.

Professor of Clinical and Operative Surgery

WM. T. LUSK, M. D.

Professor of Obstetrics and Diseases of women and children and Clinical Midwifery.

EDMUND R. PEASLEE, M. D., LL. D.

Professor of Gynaecology.

PROFESSORS OF SPECIAL DEPARTMENTS, ETC.

HENRY D. NOYES, M. D.

Professor of Ophthalmology and Otology.

JOHN P. GRAY, M. D., LL. D.

Professor of Psychological Medicine and Medical Jurisprudence.

EDWARD L. KEYES, M. D.,

Professor of Dermatology, and adjunct to the Chair of Principles of Surgery.

A distinctive feature of the method of instruction in this College is the union of clinical and didactic teaching. All the lectures are given within the Hospital grounds. During the Regular Winter Season, in addition to four didactic lectures on every week-day except Saturday, two or three hours are daily allotted to clinical instruction.

The Spring Session consists chiefly of Recitations from Text-books. This term continues from the first of March to the first of June. During this Session, daily recitations in all the departments are held by a corps of examiners appointed by the regular faculty. Regular clinics are also given in the Hospital and College Building.

FEES FOR THE REGULAR SESSION.

Fees for Tickets to all the Lectures during the Preliminary and Regular term,	\$ 10.00
including Clinical Lectures.....	
Matriculation fee.....	5 00
Demonstrator's Ticket (including material for dissection),	10.00
Graduation Fee	30.00

FEES FOR THE SPRING SESSION.

Matriculation (Ticket good for the following Winter).....	\$ 5.00
Recitations, Clinics and Lectures.....	35.00
Dissection (Ticket good for the following Winter).....	10.00

Students who have attended two full Winter courses of lectures may be examined at the end of the second course upon Materia Medica, Physiology, Anatomy and Chemistry, and if successful, they will be examined at the end of their third course upon Practice of Medicine, Surgery and Obstetrics only.

For the Annual Circular and Catalogue, giving regulations for graduation and other information, address PROF. AUSTIN FLINT, JR., Sec'y, Bellevue Hospital Medical College.

12
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The Collegiate Year in this Institution embraces a READING AND RECITATION TERM and a REGULAR TERM OF LECTURES.

The READING and RECITATION TERM will commence the first week in October, and close at the commencement of the Regular Term.

The REGULAR TERM will open the first week in March, and close the last week in June following.

For circulars address

DEAN or REGISTRAR.

Medical Department
OF THE
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NEW ORLEANS.

FACULTY:

A. H. CENAS, M. D., Emeritus Professor of Obstetrics and Diseases of Woman and Children.	[Professor of General and Clinical Obstetrics and Diseases of Women and Children.
T. G. RICHARDSON, M. D., Professor of General and Clinical Surgery.	JOSEPH JONES, M. D., Professor of Chemistry and Clinical Medicine.
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STANFORD E. CHAILLE, M. D., Professor of Physiology and Pathological Anatomy.	JOHN B. ELLIOTT, M. D.; Professor of Materia Medica and Therapeutics,
FRANK HAWTHORN, M. D.,	ALBERT B. MILES, Demonstrator of Anatomy.

The next annual course of instruction in this department (now in its forty fourth year of its existance) will commence on Monday, the 12th day of November, 1877, and terminate on Saturday the 9 day of March, 1878. Preliminary Lectures on Clinical Medicine and Surgery will be delivered in the amphitheater of the Charity Hospital, beginning on the 20 of October, without any charge to students.

The means of teaching now at the command of the Faculty are unsurpassed in the United States. Special attention is called to the opportunities presented for

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The Act establishing the University of Louisiana gives the Professors of the Medical Department the use of the Charity Hospital, as a school of practical instruction.

The Charity Hospital contains nearly 700 beds, and received, during the last year, nearly six thousand patients. Its advantages for professional study are unsurpassed by any similar institution in this country. The Medical, Surgical and Obstetrical Wards are visited by the respective Professors in charge daily, from eight to ten o'clock A. M., at which time all the Students are expected to attend and familiarize themselves, *at the bedside of the patients*, with the diagnosis and treatment of all forms of injury and disease.

The regular lectures at the Hospital, on Clinical Medicine by Professors Bemiss, Elliot and Joseph Jones, Surgery by Professors Richardson and Logan, Diseases of women and children by Professor Lewis, and Special Pathological Anatomy by Professor Chaille, will be delivered in the Amphitheater on Monday, Wednesday, Thursday, and Saturday, from 10 to 12 o'clock, A. M.

The Administrators of the Hospital, elect annually twelve resident students, who are maintained by the Institution. All vacancies are filled by competitive examinations.

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University of the City of New York.

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THIRTY-SEVENTH SESSION.—1877-78.

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ALFRED C. POST, M. D., LL.D., Professor Emeritus of Clinical Surgery; President of the Faculty.	WILLIAM H. THOMSON, M. D., Professor of Materia Medica and Therapeutics.
CHARLES INSLEE PARDEE, M. D., Professor of Diseases of the Ear; Dean of the Faculty.	J. W. S. ARNOLD, M. D. Professor of Physiology and Histology.
MARTYN PAYNE, M. D., LL. D., Professor Emeritus of Materia Medica and Therapeutics.	JOHN T. DARBY, M. D. Professor of Surgery.
JOHN C. DRAPER, M. D. LL. D., Professor of Chemistry.	J. WILLISTON WRIGHT, M. D., Professor of Obstetrics and Diseases of Women and Children.
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POST GRADUATE FACULTY.

D. B. ST. JOHN ROOSA, M. D., Professor of Ophthalmology.	MONTROSE A. PALLETT, M. D., Professor of Gynaecology.
WM. A. HAMMOND, M. D., Professor of Diseases of the Mind and Nervous System.	HENRY G. PIFFARD, M. D., Professor of Dermatology.
STEPHEN SMITH, M. D., Professor of Orthopedic Surgery.	A. E. MACDONALD, M. D., Professor of Medical Jurisprudence.
J. W. S. GOULEY, M. D., Professor of Diseases of the Genito-Urinary System.	JOSEPH W. HOWE, M. D., Clinical Professor of Surgery.

THE COLLEGIATE YEAR is divided into three Sessions, a Preliminary Session, a Regular Winter Session, and a Spring Session,

THE PRELIMINARY SESSION will commence September 19, 1877, and continue until the opening of the Regular Winter Session. It will be conducted with the plan of that Session,

THE REGULAR WINTER SESSION will commence on the Third of October, 1877 and end about the 1st of March, 1878.

The location of the new College edifice being immediately opposite the gate of Bellevue Hospital, and a few steps from the ferry to Charity Hospital, Blackwell's Island the students of the University Medical College are enabled to enjoy the advantages afforded by these Hospitals, with the least possible loss of time. The professors of the practical Chairs are connected with the Hospitals, and the University Students admitted to ALL THE CLINICS given therein, FREE OF CHARGE.

In addition to the daily Hospital Clinics, there are eight Clinics each week in the College Building. Five Didactic Lectures will be given daily in the College building and Evening Recitations will be conducted by the Professors of Chemistry, Practical Anatomy, Materia Medica, &c. Physiology, Surgery and Obstetrics, upon the subjects of their Lectures.

THE SPRING SESSION embraces a period of twelve weeks, beginning in the first week of March and ending the last week of May. The daily clinics, Recitations and Special Practical Courses will be the same as in the Winter Session, and there will be Lectures on special Subjects by the Members of the Post-Graduate Faculty.

THE DISSECTING ROOM is open throughout the entire Collegiate year: material is abundant, and it is furnished free of charge.

STUDENTS WHO HAVE STUDIED TWO YEARS may be admitted to examination in Chemistry, Anatomy and Physiology, and if successful, will be examined at the expiration of their full course of study, on Practice, Materia Medica, Therapeutics, Surgery and Obstetrics: but those who prefer it may have all their examinations at the close of their full term.

FEES.

For Course of Lectures,	\$140 00
Matriculation,	5 00
Demonstrator's fee, including material for dissection,	10 00
Graduation Fee,	31 00
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They are recommended for the utmost accuracy of composition, and their perfect preservation.

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